CONFIDENTIAL

MEDICAL HISTORY

Date_____

Patient Name _____ Date of Birth _____

Check (✓) Yes or No for the following:

AIDS/HIV Positive	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Nasal Obstruction	❑ Yes ❑ No
Allergies	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Neurological Problems	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Endocarditis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Fibromyalgia	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Asthma or Hay Fever	❑ Yes ❑ No	Heart Attack	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
		Hemophilia	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Hepatitis Type _____	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Swollen Feet or Ankles	❑ Yes ❑ No
Cancer Therapy	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Claustrophobia	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Tumor or growth on head or neck	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
COPD	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Measles or mumps	❑ Yes ❑ No		
Cough, persistent or bloody	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		

Adverse reaction to any medication or drug or food ❑ Yes ❑ No

Please specify _____

_____

Have you had any serious illnesses or surgeries? ❑ Yes ❑ No If yes, describe _____

_____

_____

Women: Are you pregnant? ❑ Yes ❑ No Nursing ❑ Yes ❑ No

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor

Check (✓) your current use of:

Tobacco ❑ Yes ❑ No
Quantity _____

Alcohol, Beer, Wine ❑ Yes ❑ No
Quantity _____

Street Drugs ❑ Yes ❑ No
Quantity _____

Physician Name_____ Phone ( ) _____

Pharmacy Name _____ Phone ( ) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient